

Health Maintenance Organizations

Health Maintenance Organizations

Table of Contents

Introduction	57
2007 HMO Service Areas	58
BlueChoice HealthPlan	59
2007 Benefits at a Glance	59
Primary Care Physician	60
Network Benefits	60
Covered Services	61
Exclusions and Limitations	65
Other Plan Features	67
Appeals	68
CIGNA HMO	70
Network Benefits	70
Out-of-Network Benefits	71
Other Plan Features	71
Claims	71
Appeals	71
MUSC Options	73
Introduction	73
2007 Benefits at a Glance	73
Your Personal Physician	76
Network Benefits	76
Covered Services	77
Prescription Drug Program	80
Exclusions and Limitations	81
Other Plan Features	83
Appeals	84

Introduction

What Are My Choices?

Your health plan options include the State Health Plan, traditional Health Maintenance Organization (HMO) plans, a Point of Service (POS) plan, and, if TRICARE eligible, the TRICARE Supplement. BlueChoice® HealthPlan of South Carolina, Inc., and CIGNA process claims for the HMO plans. BlueChoice HealthPlan processes claims for the Point of Service plan, MUSC Options.

All health plans offered through EIP, including the HMOs, are self-insured, with the exception of the TRICARE Supplement. Your monthly premium, combined with other subscribers' premiums and your employer's contribution, is placed in a trust account maintained by the state to pay claims and administrative costs. Any interest earned on this account helps fund the program.

These options are available:

- **BlueChoice HealthPlan**
- **CIGNA HMO**
- **MUSC Options (POS).**

Traditional HMO Plans

This is a plan in which subscribers must use only healthcare providers, including hospitals, within the HMO's network. If you receive care outside this network, the plan will not pay benefits unless the care was pre-authorized or deemed an emergency. You must choose a Primary Care Physician (PCP) who coordinates your healthcare. To receive benefits when you see a specialist, you must first receive a referral from your PCP.

Point of Service (POS) Plan

A POS plan allows you to go to providers inside or outside its network. To receive the maximum level of benefits, care must be obtained from providers, including hospitals, within the network and be authorized by the third-party claims processor. When you use out-of-network providers, you will probably have much higher out-of-pocket expenses in the form of deductibles and copayments. The only POS plan is MUSC Options, which is available only in Berkeley, Charleston, Colleton and Dorchester counties.

Plan Descriptions

A description of each option is included in this guide. If you wish to use specific physicians, hospitals and other providers, see if they are part of the network of the plan you are considering. To receive benefits, your provider must be part of your network.

Refer to pages 198-203 for premiums and a comparison of benefits. For more information, active employees should contact their benefits administrator, the third-party administrator or EIP. Retirees, COBRA subscribers and survivors should contact the third-party administrator or EIP. Telephone numbers and Web sites are listed on the inside covers of this book.



A Valuable Preventive Benefit:

If BlueChoice HealthPlan, CIGNA HMO or MUSC Options is your primary health plan, you may participate yearly in a worksite screening sponsored by Prevention Partners. For a \$15 fee, you will receive a comprehensive health appraisal that includes a blood test and an evaluation of your risk factors. Check with your benefits administrator to find out when a screening is scheduled in your area.

2007 HMO SERVICE AREAS

	COUNTY	HMO CHOICES
1	Anderson, Greenville, Oconee, Pickens	BlueChoice Health Plan CIGNA HMO
2	Cherokee, Spartanburg, Union	BlueChoice HealthPlan CIGNA HMO
3	Chester, Lancaster, York	BlueChoice HealthPlan CIGNA HMO
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	BlueChoice HealthPlan
5	Fairfield, Kershaw, Lexington, Newberry, Richland	BlueChoice HealthPlan CIGNA HMO
6	Aiken, Barnwell, Edgefield	BlueChoice HealthPlan
7	Allendale, Bamberg, Calhoun, Orangeburg	BlueChoice HealthPlan CIGNA HMO
8	Clarendon, Lee, Sumter	BlueChoice HealthPlan CIGNA HMO
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	BlueChoice Health Plan CIGNA HMO
10	Georgetown, Horry	BlueChoice Health Plan CIGNA HMO
11	Berkeley, Charleston, Colleton, Dorchester	BlueChoice, CIGNA HMO, MUSC Options
12	Beaufort, Hampton, Jasper	BlueChoice, CIGNA HMO

BlueChoice HealthPlan

BlueChoice HealthPlan is a traditional HMO offered statewide.

With BlueChoice HealthPlan, you select a Primary Care Physician (PCP) to coordinate your healthcare. If you need services your PCP does not offer, he or she will refer you to a qualified specialist in the network.

BlueChoice HealthPlan offers a wide range of programs designed to keep you healthy. Preventive care is a key feature of the plan. As a member, you simply pay a small copayment for your well-child visits and immunizations, as well as for any primary care visit.

2007 BENEFITS AT A GLANCE

To be covered, services must be provided by your Primary Care Physician (PCP) or authorized in advance by your PCP and BlueChoice HealthPlan, unless otherwise noted. The Plan of Benefits governs all health benefits offered through EIP.

BENEFITS	MEMBER PAYS
Deductible per Calendar Year Per Member Per Family	\$250 \$500
Coinsurance Maximum per Calendar Year Per Member Per Family	\$1,500 \$3,000
Lifetime Benefit Maximum - \$1,000,000	
Primary Care Physicians Office services, including routine and preventive care Hospital services Routine mammogram	\$15 Copayment per visit \$0 \$0
Specialty Care Physicians Office services Maternity care Hospital services Emergency room care Routine GYN exam - two per calendar year Chiropractic care - \$1,000 maximum per calendar year	<i>All services must be pre-authorized</i> \$30 Copayment per visit \$30 Copayment first visit, then 10% Deductible, then 10% Deductible, then 10% \$15 Copayment per visit (<i>Authorization not required</i>) \$30 Copayment per visit
Facility Services Inpatient admission Skilled Nursing Facility and/or Long-Term Acute Care Facility - 120-day maximum per calendar year Outpatient services Emergency room services	<i>All services, except emergency care must be pre-authorized</i> \$200 Copayment per admission, then 10% Deductible, then 10% \$75 Copayment and 10% for first 3 visits per calendar year; 10% for visit 4 and each visit thereafter \$100 Copayment per visit, then 10%
Urgent Care Inside the local service area	\$35 Copayment per visit at a participating Urgent Care Provider
Prescription Medication Retail Copayment (<i>up to a 31-day supply</i>) Mail-order Copayment (<i>up to a 90-day supply</i>)	\$8 Generic drug \$30 Preferred brand-name drug \$50 Non-preferred brand-name drug \$16 Preferred brand-name drug \$60 Preferred brand-name drug \$100 Non-preferred brand-name drug
Specialty Pharmaceuticals	\$75 Copayment per 31-day supply

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians Eyecare Network (PEN) Providers Only (Refer to Provider Directory) One routine eye exam for eyeglasses per calendar year One pair of eyewear from a designated selection every other calendar year <i>(other discounts and/or fees will apply to glasses and contact lenses outside of the designated selection)</i> <i>Fitting exam for contact lenses per calendar year</i>	\$0 \$0 \$45
Other Services Ambulance Hospice Medical supplies Initial prosthetic appliances Outpatient private duty nursing and home health Dental services due to accidental injury \$500 maximum per calendar year Durable medical equipment (DME) \$5,000 maximum per calendar year	<i>All services, except emergency care, must be pre-authorized</i> Deductible, then 10% Deductible, then 10% Deductible, then 10% Deductible, then 10% Deductible, then 10% Deductible, then 10% Deductible, then 10%
Human Organ Transplants <i>Lifetime Transplant Maximum</i> Covered Transplants:	\$250,000 Maximum benefit per transplant:
Kidney (single) Pancreas/kidney Heart Lung (single) Liver Pancreas Heart/lung	\$60,000 \$80,000 \$120,000 \$130,000 \$225,000 \$80,000 \$175,000

PRIMARY CARE PHYSICIAN

At enrollment, you must select a Primary Care Physician (PCP) from BlueChoice HealthPlan's network. Your PCP coordinates all health services covered under your plan. Each member of your family may select a different PCP. When you need to see a specialist or other healthcare professional, your PCP will refer you to a network provider. BlueChoice HealthPlan will cover those healthcare services according to this Plan of Benefits.

You may change your PCP at any time by calling Member Services at 800-868-2528 or visiting our Web site at www.BlueChoiceSC.com.

NETWORK BENEFITS

With BlueChoice HealthPlan, you receive benefits for covered services only when you go to participating (network) physicians, hospitals and other healthcare providers. Network providers will:

- File covered expense claims for you
- Ask you to pay only the deductible, copayment and/or coinsurance amounts (if any) for covered expenses
- Accept the plan's payment for covered expenses as payment-in-full, minus any copayment or coinsurance due.

Referrals

Should you need medical care your PCP cannot provide, he or she will refer you to another network provider. Remember, to ensure that BlueChoice HealthPlan will pay for the visit to the specialist, make sure your doctor has made the referral before you visit the specialist. If you receive care from a specialist without a referral from your PCP, BlueChoice HealthPlan will cover services only if they are related to a medical emergency. You can check for referrals on our Web site at www.BlueChoiceSC.com.

Note: Women may go to a participating gynecologist twice a year without a referral from their PCP. Women may also go to any participating obstetrician for prenatal care.

Finding a Network Provider

A complete list of providers is at www.BlueChoiceSC.com. If you would like a copy of the Provider Directory, you may request one by calling Member Services at 800-868-2528. You may also ask Member Services for more information about providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in providers and about which ones are accepting new patients.

Deductible

A deductible is the amount you must pay each year before the plan begins to pay benefits. BlueChoice HealthPlan's annual deductible is \$250 for individuals and \$500 for families.

The deductible does not apply to:

- Any services from your PCP, such as office visits, routine physicals and well-child care and immunizations
- Office visits to specialists
- Retail and mail-order pharmacy benefits
- Specialty drugs
- Routine mammograms.

Coinsurance

Coinsurance is the percentage of the cost of medical services that you pay. As a BlueChoice HealthPlan member, you pay 10 percent of the cost of network hospital and emergency services after you meet your deductible. After you spend either \$1,500 (individual coverage) or \$3,000 (family coverage) in coinsurance, out-of-pocket, in a calendar year for network services, the plan will pay 100 percent of your medical costs for network services for the remainder of the calendar year. Copayments do not count toward your out-of-pocket coinsurance limit or your deductible.

Copayment

A copayment is the fixed dollar amount you pay when you receive services. The copayment will vary depending on the type of care you receive. Your annual deductible does not affect copayments. You must make your copayments whether you have met your deductible or not.

COVERED SERVICES

To be covered, services must be provided by your PCP or by another network provider. Services provided by another network provider must be authorized in advance by your PCP and by BlueChoice HealthPlan, unless it is a medical emergency or otherwise noted in the Schedule of Benefits.

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.

Chiropractic Care

You are covered for office services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic x-rays are covered if medically necessary. Other services that are within the scope of the practice of chiropractic are also covered.

Maternity Care

You and your dependent spouse are covered for hospital care, birthing center care, and prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. Inpatient benefits are provided for the mother and newborn for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Caesarean section, not including the day of surgery. Coverage for the newborn includes, but is not limited to, routine nursery care and/or routine well-baby care during this period of hospital confinement. Charges for home births are not covered. Pregnancy is not considered a pre-existing condition.

Inpatient Hospital Services

You are covered for inpatient hospital services at an acute care hospital, a skilled nursing facility, or a long-term acute care hospital, including room and board, physician visits and consultations.

Outpatient Hospital Services

Charges for outpatient laboratory, X-ray, surgery, and diagnostic tests are covered. Physical therapy, occupational therapy and speech therapy are also covered, subject to the limits listed in the Schedule of Benefits.

Rehabilitation Services

You are covered for short-term (60 days from the start of treatment) rehabilitation services that are expected to significantly improve your condition. Rehabilitation services are limited to physical therapy, occupational therapy, speech therapy and cardiac therapy. Speech therapy is covered only when used to restore speech abilities that have been lost due to injury or illness. Cardiac therapy is covered only following a major cardiac event.

Therapeutic Services

Charges for radiation therapy, cancer chemotherapy and respiratory therapy are covered.

Behavioral Health Services

You are covered for treatment of mental health conditions and substance abuse. Companion Benefit Alternatives (CBA) coordinates benefits for these services. To receive services from a mental health or substance abuse professional, you or your primary care physician may contact CBA at 800-868-1032 for authorization and/or more information. Services provided at a residential treatment center are not covered.

Emergency Services and Urgent Care

Emergency Services

You are covered for treatment of a true medical emergency anywhere in the world. If practical, you should call your PCP first and follow his or her directions. However, in a serious medical emergency, go to the nearest hospital or treatment center for help or call 911. You should then have someone notify your doctor and BlueChoice HealthPlan.

BlueChoice HealthPlan will cover emergency room care only if you are seeking treatment for symptoms that are severe and need immediate medical attention, or if your doctor authorized the emergency room visit. Conditions that are considered a medical emergency include those so severe that if you do not get immediate medical attention, one of the following could occur:

- Severe risk to your health, or with respect to pregnancy, the health of your unborn child
- Serious damage to body function
- Serious damage to any organ or body part.

Follow-up care for emergency services must be received from providers within the BlueChoice HealthPlan network or arranged by BlueChoice HealthPlan.

For more information on receiving emergency services outside the BlueChoice HealthPlan service area, please review the section on the BlueCard® program.

Urgent Care

Urgent care is a medical condition that is serious but not life- or limb-threatening. If you need urgent care, you should call your PCP. If you have an illness or injury that requires urgent care and you cannot get to your doctor or wait until normal business hours, you should go to a participating urgent care center. Please refer to the BlueChoice HealthPlan Provider Directory for the list of participating urgent care centers.



For more information about the BlueCard program, see page 29 of this guide.

Urgent care required within South Carolina is covered when provided by a participating urgent care provider. Urgent care required outside South Carolina is covered when coordinated through the BlueCard program.

Prescription Medicine

Prescription drugs, including insulin, are covered, subject to plan exclusions and limitations, if you use a participating pharmacy. You may purchase up to a 31-day supply of a covered prescription medication at a participating retail pharmacy and up to a 90-day supply through a participating mail-order pharmacy. Not all medications are available through the mail-order pharmacy. Please refer to the BlueChoice HealthPlan Preferred Drug List for a list of prescription drugs covered under your pharmacy benefits.

Generics Now^{sm†}

Generic drugs are equivalent in composition and effect to their brand-name counterparts but are generally less expensive. BlueChoice HealthPlan has implemented a program called “Generics Now” to encourage the use of generic drugs. If your doctor prescribes a brand-name drug but allows you to substitute an equivalent generic drug if one is available, you should consider buying the generic drug. Here is why—if you request the brand-name drug over the generic drug, you will be required to pay the difference between the cost of the brand-name drug and the generic drug. You will also have to pay the copayment for the brand-name drug. However, you will never be charged more than the retail cost of the brand-name drug.

Specialty Pharmaceuticals

Specialty pharmaceuticals are prescription drugs used to treat complex clinical conditions with complex delivery of care and distribution requirements. They include, but are not limited to, infusible specialty drugs for chronic disease, injectable and self-injectable specialty drugs for acute and chronic disease, and specialty oral drugs. Specialty pharmaceuticals are covered when purchased from a designated participating provider and prescribed by a participating physician. You may obtain a list of specialty pharmaceuticals by contacting BlueChoice HealthPlan Member Services at 800-868-2528 (786-8476 in the Columbia area).

Prior Authorization

Certain prescription drugs require prior authorization in order to be covered, and certain drugs have dosage limits as determined by BlueChoice HealthPlan. Please review your BlueChoice HealthPlan Preferred Drug List for information on which drugs require prior authorization and/or have dosage limits.

Vision Services

You are covered for one comprehensive vision examination each calendar year to determine the need for corrective eyeglass lenses. A member of the Physicians Eyecare Network must perform the exam. Additional charges for a contact lens examination and contact lens fitting are not covered.

You are covered for one pair of eyeglasses from a designated selection of lenses and frames from a member of the Physicians Eyecare Network every other calendar year. If you prefer contact lenses, the eyeglass benefit may be used as a credit toward a contact lens package. No other vision or eye examination is covered unless determined to be medically necessary to treat a medical condition and pre-authorized by your PCP and BlueChoice HealthPlan.

For a listing of Physicians Eyecare Network providers, please visit the BlueChoice HealthPlan Web site at www.BlueChoiceSC.com or refer to your Provider Directory.

Ambulance Services

Charges for emergency ambulance transportation, provided by a licensed ambulance service to the nearest hospital where emergency covered services can be rendered, are covered. Coverage includes transportation between acute care facilities when a medically indicated transfer is needed.

Hospice

You are covered for hospice care provided by a licensed hospice.

Medical Supplies

Charges are covered for medical supplies, including, but not limited to:

- Dressings requiring skilled application, for conditions such as cancer or burns
- Catheters
- Colostomy bags and related supplies
- Medically necessary supplies for renal dialysis equipment or machines
- Surgical trays
- Splints or such supplies as needed for orthopedic conditions
- Syringes, test tapes and other related diabetic supplies not covered under other provisions of the plan.

Outpatient Private Duty Nursing Care and Home Health Services

You are covered for special or private duty nursing care provided by a registered nurse or a licensed practical nurse, on an outpatient basis, for up to 60 days each calendar year. Services must be provided in lieu of inpatient care.

You are also covered for home health services provided by a licensed home health agency. Services must be provided in lieu of inpatient care.

Prosthetics

You are covered for a prosthetic device, other than a dental or cranial prosthetic, that is a replacement for a body part and meets minimum specifications. Only the initial prosthesis is covered.

Dental Services for Accidental Injuries

You are covered for dental services performed by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) to sound natural teeth when required because of accidental injury. For purposes of this benefit, an accidental injury is defined as an external traumatic force such as a car accident or blow by a moving object. The first (emergency) visit to the dentist does not require authorization. However, the dentist must submit an outline of the plan for future treatment to BlueChoice HealthPlan for review and approval before continuing with follow-up care for that care to be covered. Follow-up care must be completed within six months of the accident.

Durable Medical Equipment

Charges for medically necessary durable medical equipment, such as wheelchairs, braces, hospital beds, traction equipment, inhalation therapy equipment and suction machines, and other equipment as approved by BlueChoice HealthPlan for outpatient use, are covered. Equipment is covered only when ordered, delivered and used while you are enrolled with BlueChoice HealthPlan. *Durable medical equipment is not covered out of network.*

Repair, replacement or duplicates of durable medical equipment are not covered, except when medically necessary due to a change in your medical condition. Appliances that serve no medical purpose and are solely for your comfort, such as a whirlpool bath, air conditioner or dehumidifier, are not covered.

Reconstructive Surgery after Mastectomy

If you are receiving benefits in connection with a mastectomy and/or elective breast reconstruction in connection with the mastectomy, you are covered for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications during all stages of mastectomy including lymphedemas.

This coverage is in compliance with the Women's Health and Cancer Rights Act of 1998.

Human Organ Transplant Services

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient) and provided at a designated transplant facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation, are covered.

Coverage for charges incurred by a living donor are limited to those for medical and surgical expenses for care and treatment, but only if the donor and recipient are both covered by the Employee Insurance Program.

Transplants that are experimental, investigational or unproven are not covered. Transplants that are not determined by BlueChoice HealthPlan to be medically necessary are also not covered.

EXCLUSIONS AND LIMITATIONS

No benefits are provided for the following, unless otherwise specified in the Schedule of Benefits or the Covered Services section.

1. Any services or supplies that are not medically necessary.
2. Any services or supplies for which you are not legally obligated to pay.
3. Any services or supplies for treatment of military service-related disabilities when you are legally entitled to other coverage and for which facilities are reasonably available to you.
4. Any services or supplies for which benefits are paid under Workers' Compensation, occupational disease law or similar legislation.
5. Treatment of an illness contracted or injury sustained while engaged in the commission of or attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation (job); or treatment of an injury or illness due to voluntary participation in a riot or civil disorder.
6. Any charges for services provided before your effective date or after termination of coverage.
7. Admissions or portions thereof for sanitarium care, rest cures or custodial care.
8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery.
9. All services and supplies related to pregnancy of a dependent child. (Complication of pregnancy is covered. However, abortion is not considered a complication of pregnancy.)
10. Services, supplies or drugs for the treatment of infertility, including, but not limited to, artificial insemination and in-vitro fertilization; fertility drugs; reversal of sterilization procedures and surrogate parenting.
11. Pre-conception testing, pre-conception counseling or pre-conception genetic testing.
12. Any drugs, services, treatment or supplies determined by the medical staff of BlueChoice HealthPlan to be experimental, investigational or unproven.
13. Drugs for which there is an over-the-counter equivalent; all vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for non-covered therapies, services or conditions; and drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility or smoking cessation.

14. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are medically necessary and due to physical trauma, surgery or congenital anomaly (birth defect).
15. Therapy or services for learning disabilities, speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation or marriage counseling.
16. Any drugs, services, treatment or supplies for the diagnosis or treatment of sexual dysfunction unless medically necessary for the treatment of a medical condition or organic disease, and then only with prior authorization. This includes, but is not limited to, drugs, laboratory and X-ray tests, counseling, and penile implants or prostheses.
17. Services or supplies related to dysfunctional conditions of the muscles of mastication; malpositions or deformities of the jaw bone(s); and orthognathic deformities or temporomandibular joint (TMJ) disorders, including, but not limited to, appliances and orthodontia.
18. Dental work or treatment that includes hospital or professional care in connection with:
 - a. Any operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury to natural teeth due to an accident.
 - b. Orthodontic care or treatment of malocclusion.
 - c. Operations on, or treatment of or to, the teeth or supporting bones and/or tissues of the teeth, except for removal of malignant tumors or cysts or treatment of an injury to natural teeth due to an accident.
 - d. Removal of teeth, whether impacted or not.
 - e. Any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of, a dental implant.

This exclusion does not apply if the dental work involves facility and anesthesia services that are medically necessary because of a specific organic medical condition such as congestive heart failure or chronic obstructive pulmonary disease that requires hospital-level monitoring.
19. Hearing aids.
20. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction or completion of medical records, itemized bills or claims forms.
21. Services or supplies not specifically listed in the Schedule of Benefits and the Covered Services section.
22. Transplants other than as specified in the Schedule of Benefits.
23. Complications arising during, from or related to the receipt of non-covered services. "Complications," as used in this exclusion, includes any medically necessary services or supplies which, in BlueChoice HealthPlan's judgment, would not have been required by you had you not received non-covered services.
24. The purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, waterbeds, exercise equipment or other similar items or equipment.
25. Any service or supply provided by a member of your family or by yourself, including the dispensing of drugs. A member of your family means your spouse, parent, grandparent, brother, sister, child or your spouse's parent.
26. Charges for acupuncture, hypnotism, biofeedback and TENS unit. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow you to develop pain-coping skills and freedom from dependence of analgesic medications.
27. Services not provided by or under the direction of your Primary Care Physician, except covered services or referred services authorized in advance by BlueChoice HealthPlan.
28. Treatment or surgery for obesity, morbid obesity, weight reduction or weight control, including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures, the reversal of such procedures, and services required as a result of complications from such procedures including reconstructive procedures necessitated by weight loss.
29. Orthomolecular therapy, including nutrients, vitamins and food supplements, that is aimed at or related to restoring the optimal concentrations and molecular level functions of substances such as non-traditional vitamins and base elements in the body through the use of macrobiotics.
30. Radial keratotomy, myopic keratomileusis, LASIK surgery, and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting vision problems such as myopia, hyperopia or stigmatic error.
31. Treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices; services and supplies for non-surgical treatment of the feet; and cutting, removal or treatment of corns, calluses

or nails. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease.

32. Infant formula, nutrition counseling, lifestyle improvements and physical fitness programs.
33. Communications, travel time and transportation, except for professional ambulance services.
34. Cranial orthotics used on infants with misshapen heads to progressively mold the skull to a normal shape.
35. Sclerotherapy for cosmetic purposes, such as removal of spider veins.
36. Growth hormone therapy for patients over 18 years of age. (Growth hormone therapy for patients age 18 and younger with documented growth hormone deficiency is covered.)
37. Pulmonary rehabilitation, except in conjunction with a covered lung transplant.
38. Any procedures, drugs, treatment or services for or related to an elective abortion.
39. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges.

OTHER PLAN FEATURES

Away From Home Care

Any time you or one of your family members will be out of South Carolina for more than 90 days, you can become a guest member of an affiliated BlueCross and BlueShield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two groups that can benefit from Away From Home Care. If you need to use the Away From Home Care program, call Member Services at 800-868-2528 (786-8476 in the Columbia area) and ask to speak to the Away From Home Care program coordinator, or visit www.BlueChoiceSC.com for more information.

Great Expectations^{®†} for health

As your partner in good health, one way BlueChoice HealthPlan can help you reach your health goals is through the Great Expectations *for health* programs. These programs are designed to help you improve your overall health by providing you with written educational information and professional support from a team of health specialists. BlueChoice HealthPlan members may participate in these programs at no charge or for a small, one-time fee.

Great Expectations *for health* offers programs for:

- Asthma
- Children's Health
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- Maternity
- Men's Health
- Migraine
- Quit Smoking
- Women's Health
- Weight Management.

For more information on these programs, please call our Health Management department at 800-327-3183, ext. 25541, or you may visit www.BlueChoiceSC.com.

Value-Added Services

There are many ways to stay healthy. That is why Value-Added Services are offered to BlueChoice HealthPlan members. These services and discounts are in addition to (but not a part of) the services and benefits covered under a BlueChoice HealthPlan policy.

Through the Natural Bluesm program, you have access to special discounts on services from a network of acupuncturists; massage therapists, chiropractors and day spas and fitness centers in South Carolina and throughout the country.

Additional Value-Added Services include discounts for:

- LASIK services
- Alternative medicine
- Hearing tests and aids
- Weight loss programs and centers
- Magazine subscriptions
- Cosmetic surgery
- Cosmetic dentistry.

For more information or to find a provider, call Member Services at 800-868-2528 or visit www.BlueChoiceSC.com.

APPEALS

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received.

To request an appeal, you (or your designated representative) may contact Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area). If you prefer, you may send a written appeal request to:

BlueChoice HealthPlan
Member Services (AX-425)
P.O. Box 6170
Columbia, SC 29260-6170.

You may also e-mail your appeal request to BlueChoice HealthPlan through its Web site at www.BlueChoiceSC.com. Just sign on to *My Insurance Manager^{sm†}* and click on “Ask Customer Service.”

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal and send you notification of that decision within 30 days of receipt of your appeal request.

If you are dissatisfied with the decision, you may ask for a review by sending a written request to EIP, within 90 days of receiving notice of the decision on your appeal. If the EIP Appeals Committee upholds BlueChoice HealthPlan’s decision, you will have 30 days to seek review in the Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

If you need more information about the appeal process, please contact BlueChoice HealthPlan by phone, letter or e-mail as indicated above.

WEB SITE: WWW.BLUECHOICESC.COM

If you wish to download forms, learn specifics about your health plan, send BlueChoice HealthPlan an e-mail, review the Prescription Drug List or read about Wellness programs, you can do all that and more by visiting www.BlueChoiceSC.com. This Web site is a protected, secure and convenient way for you to have access to timely information on your own schedule.

My Insurance Manager enables you to:

- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you have paid toward your deductible or out-of-pocket limit
- Ask a customer service question through secure e-mail

- Request a new ID card
- Access *My Pharmacy Manager*.

My Pharmacy Manager enables you to:

- View your prescription history
- Find information about medications you are taking or are considering taking
- Learn about potential therapeutic options to discuss with your physician
- Compare drug costs.

CIGNA HMO

CIGNA HMO, a traditional HMO plan administered by CIGNA HealthCare, is available in all counties in the state **except**: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Primary Care Physician

With CIGNA HMO, your primary care physician (PCP) is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and X-ray services and hospital admissions.

When you enroll in CIGNA HMO, you and each covered member of your family chooses his or her own PCP. A woman may select an OB/GYN in addition to her PCP. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

NETWORK BENEFITS

With CIGNA HMO, you normally receive benefits for covered services **only** when you receive those services from participating physicians, hospitals and other healthcare providers. Network providers will:

- File claims for covered expenses for you
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered expenses.

Copayments

Copayment amounts vary depending on the services you receive. The CIGNA HMO plan has no annual deductible. Copayments for doctor and hospital services under the plan are:

- \$20 PCP office visit
- \$40 OB/GYN visit
- \$40 specialist office visit
- \$500 per inpatient hospital admission
- \$250 outpatient surgery and medical care
- \$100 emergency care
- \$500 per admission for inpatient mental health and substance abuse care
- \$40 outpatient mental health and substance abuse office visit.

Coinsurance

You are responsible for 20 percent of the cost of hospital services received from network providers, in addition to the copayments. Emergency room services are covered at 100 percent after the copayments.

Coinsurance Maximum

Once you have spent either \$2,000* (individual coverage) or \$4,000* (family coverage) out of your pocket in a year for network services, the plan will pay 100 percent of your covered medical costs for the rest of the year.

**Inpatient and outpatient hospital copayments and coinsurance count toward your out-of-pocket maximum. However, other copayments do not.*

Prescription Drugs

The CIGNA plan provides prescription drug coverage. With CIGNA HMO, you **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a non-participating pharmacy. Copayments for up to a 30-day supply are:

- \$ 7 for generics
- \$25 for preferred brands
- \$50 for non-preferred brands.

CIGNA HMO offers an online prescription center (CIGNA TelDrug) that allows you to order prescriptions and refills for home delivery, review the list of covered drugs and check the status of a recent order 24 hours a day. The copayments for up to 90-day supply are:

- \$14 for generics
- \$50 for preferred brands
- \$100 for non-preferred brands.



If you or your dependent will leave your service area for more than 60 days, call 800-244-6224 to be set up with a provider network away from home. When you return, you can switch back to the South Carolina network.

OUT-OF-NETWORK BENEFITS

You may receive emergency services from out-of-network providers. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. You or a family member should tell your primary care physician and CIGNA HMO about the emergency as soon as possible.

Members who are living in a state other than South Carolina are eligible for the Guest Privileges Program, a guest membership in an HMO in the community where they live, for up to two years.

OTHER PLAN FEATURES

Other special features of the CIGNA plan include:

- **The CIGNA 24-Hour Health Information LineSM** that provides access to medical information, level-of-care counseling, an audio library of hundreds of topics and guidance to network providers.
- The **Healthy Rewards** program, which includes special offers for discounts on health-related products and services.
- **Vision care.** Subscribers receive a \$10 eye exam every two years. Not all providers participate, and you must use a participating provider.
- **Nationwide access** to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network.

CLAIMS

There is no paperwork for in-network care. Just show your CIGNA plan ID card and pay your copayment. Your provider will complete and submit the paperwork. If you visit an out-of-network provider, you or your provider must file a paper claim. You will receive an Explanation of Benefits identifying the costs covered by your plan and the charges you must pay. For more information on the claims process, please contact CIGNA HealthCare at 800-244-6224.

APPEALS

These steps must be followed if you have a concern or an appeal:

- Call or write CIGNA's Member Services Department, and a representative will work with you to resolve your concern.

- If it is not resolved to your satisfaction, you may appeal the decision to CIGNA's Appeal Committee. This is called a Level One Appeal. The Appeal Committee will notify you in writing of its decision within 30 calendar days.
- If you do not agree with the decision, you may appeal to CIGNA's Grievance Committee. This is a Level Two Appeal. The Grievance Committee will notify you in writing of its decision within 30 calendar days.

If you are still dissatisfied after CIGNA HealthCare has reviewed its decision, you may ask the Employee Insurance Program (EIP) to review the matter by making a written request to EIP within 90 days of notice of the denial. If the EIP Appeals Committee upholds the denial, you have 30 days to seek review in the Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006. For more information on the appeals process, please contact CIGNA HealthCare at 800-244-6224, or write CIGNA HealthCare at P.O. Box 5200, Scranton, PA 18505.

MUSC Options

INTRODUCTION

MUSC Options is a self-insured, Point of Service plan. Health claims are processed by BlueChoice HealthPlan. Pharmacy claims are processed by Medco Health Solutions, Inc. (See page 80 for more information about pharmacy benefits.) Permanent, full-time eligible employees who live or work in Berkeley, Charleston, Colleton or Dorchester counties may enroll. The plan is also available to retirees (including those who are eligible for Medicare), survivors and COBRA subscribers who live in this area.

This year there have been some changes in MUSC Options benefits. Effective January 1, 2007:

- **A referral from a physician** is no longer needed to see a network specialist. The copayment for a referral and a self-referral is the same, \$55.
- **Obesity surgery** is no longer covered.
- **The annual deductible for out-of-network services** has increased to \$500 for single and \$1,500 for family coverage.
- **Office visit copayments** for in-network services have increased to \$25 for a primary care physician, \$25 for an OB/GYN well woman exam, \$55 for a specialist and \$50 for urgent care.
- **The copayment for emergency care** has increased to \$150 per occurrence.
- **Retail prescription drug copayments** have increased to \$30 for preferred brands and \$50 for non-preferred brands. (The generic brand copayment remains \$10.)
- There is now a **\$100 copayment** for 31-day supply of a specialty pharmaceutical purchased from a retail pharmacy and a **\$250 copayment** for a 90-day supply purchased from a mail-order pharmacy.
- **Mail-order prescription drug copayments** have increased to \$25 for generics, \$75 for preferred brands and \$125 for non-preferred brands.
- **Before obtaining covered prescription drugs by paying a copayment, each covered person must now meet a \$100 annual deductible for covered prescription drug purchases.**

There also have been some changes in premiums. For details, see pages 198-203.

2007 BENEFITS AT A GLANCE

To receive in-network benefits, all services must be provided by a MUSC Options participating provider. This applies to each individual service unless otherwise noted.

All non-emergency hospital admissions must be authorized by BlueChoice HealthPlan to be covered.

Benefits are subject to all (if any) limitations, deductibles, coinsurance and maximum payment amounts, exclusions, and limitations as specified in the Plan of Benefits.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Deductible per Benefit Period (The benefit period is a calendar year.) Per member Per family	\$0 \$0	\$500 \$1,500
Maximum Coinsurance per Benefit Period Per member Per family	N/A N/A	\$3,000 \$9,000
Lifetime Benefit Maximum - \$1,000,000		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	Member pays	Member pays
Physician Services Primary Care Office visit Hospital visit Screening mammogram Allergy injection and serum Routine physical exam Health assessment Well baby and child care Immunizations Specialty Care (except mental health/substance abuse care) Office visit Maternity care Hospital visit Surgery at hospital Emergency room care Routine GYN exam Non-routine GYN exam Chiropractic care - spinal manipulation	\$25 copayment per visit \$0 \$0 \$25 copayment per visit \$25 copayment per visit \$25 copayment per visit \$25 copayment per visit \$25 copayment per visit \$25 copayment per visit \$55 copayment per visit \$55 copayment for first visit \$0 \$0 \$0 \$25 copayment per visit \$55 copayment per visit \$55 copayment per visit	Deductible, then 40% Deductible, then 40% 100% (not covered) Deductible, then 40% 100% (not covered) 100% (not covered) 100% (not covered) 100% (not covered) 100% (not covered) Deductible, then 40% Deductible, then 40% Deductible, then 40% Deductible, then 40% \$0 100% (not covered) Deductible, then 40% 100% (not covered)
Facility Services (Except mental health/substance abuse care) (All services must be pre-authorized except emergency care) Inpatient admission Skilled nursing facility Lesser of \$6,000 or 60 days per benefit period Outpatient services Lab and x-ray Surgical Diagnostic/therapeutic Emergency room services	\$300 copayment per admission \$0 \$100 copayment per visit for first three visits per benefit period (No copayment at MUSC) \$150 copayment per visit (Waived if admitted)	Deductible, then 40% Deductible, then 40% Deductible, then 40% \$150 copayment per visit (Waived if admitted)
Urgent Care	\$50 copayment per visit at a participating Urgent Care Provider	Deductible, then 40%
Prescription Drugs (Administered by Medco Health: 800-711-3450) Annual Pharmacy Deductible Retail —Prescription Medication dispensed by a retail pharmacy is subject to one copayment for up to a 31-day supply. Generic drug Preferred brand-name drug Non-preferred brand-name drug Specialty pharmaceuticals Mail Order —Prescription Medication dispensed by a mail-order pharmacy is subject to one copayment for up to a 90-day supply. Generic drug Preferred brand-name drug Non-preferred brand-name drug Specialty pharmaceuticals	\$100 \$10 copayment \$30 copayment \$50 copayment \$100 copayment per 31-day supply \$25 copayment \$75 copayment \$125 copayment \$250 copayment per 90-day supply	Covered only at a participating pharmacy

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	Member Pays	Member Pays
Mental Health/Substance Abuse Care (In-network providers contract with Companion Benefit Alternatives (CBA)) Members or participating providers must contact CBA at 800-868-1032 for authorization for In-network and Out-of-Network coverage. Inpatient Outpatient	 \$300 copayment per admission \$55 copayment per visit	 Deductible, then 40% Deductible, then 40%
Other Services Ambulance Home Health Lesser of \$5,000 or 100 visits per benefit period Hospice \$6,000 lifetime maximum Medical Supplies Surgical treatment of TMJ Original prosthetic appliances Outpatient mammograms Private duty nursing Rehabilitation services Physical, occupational and speech therapy are covered during the acute phase of treatment Dental services due to accidental injury within one year of accident Durable Medical Equipment (DME) Removal of bony, impacted wisdom teeth Infertility Treatment Inpatient, outpatient and prescription medication limited to three cycles; \$15,000 lifetime maximum	 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 30%	 Deductible, then 40% Deductible, then 40% Deductible, then 40% Deductible, then 40% Deductible, then 40% 100% (not covered) 100% (not covered) 100% (not covered) Deductible, then 40% 100% (not covered) 100% (not covered) Deductible, then 40% 100% (not covered)
Human Organ Transplants Inpatient Hospital care Physician care Outpatient Office visit Covered transplants All non-experimental human organ transplants	 \$300 copayment per admission \$0 \$55 copayment per visit	 Deductible, then 40% Deductible, then 40% N/A

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	Member Pays	Member Pays
Vision Care (any licensed vision care provider) Eye exam for eyeglasses or contact lenses once every benefit period Eyewear covered once every other benefit period <i>Authorization not required</i> Member pays for charges and submits claim for reimbursement Exams for the diagnosis or treatment of disease or injury to the eye (covered as a specialist visit)	Balance over \$75 Balance over \$75 \$55 copayment per visit	Balance over \$75 Balance over \$75 100% (not covered)

YOUR PERSONAL PHYSICIAN

You are not required to select a personal physician. However, MUSC Options encourages you to coordinate your healthcare through one. By doing so, you may prevent unnecessary medical expenses, and you will ensure that your personal physician is up-to-date on the care you receive.

Finding a Network Provider

A complete list of providers is at www.BlueChoiceSC.com. If you would like a copy of the Provider Directory, you may request one by calling Member Services at 800-821-3023. You may also ask Member Services for more information about providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in providers and about which ones are accepting new patients.

NETWORK BENEFITS

In the MUSC Options Network

You receive the highest level of benefits if you use the services of physicians and other providers that are part of the MUSC Options network.

You may go to a specialist in the MUSC Options network for office services without a referral from your personal physician.

Outside the MUSC Options Network

You may go to a licensed healthcare provider who is not in the MUSC Options network. However, you will be subject to coinsurance and a deductible, plus you may have to file your own claims.

Note: Not all services are covered outside the MUSC Options network. Please see “Covered Services” for more information.

Balance Billing

When you receive a covered service from a provider in the MUSC Options network, the provider is prohibited from billing you more than any applicable copayments, coinsurance and deductibles. If you choose to receive a covered service outside the MUSC Options network, the non-network provider may charge you more than

the plan's maximum allowable charge for the service. The difference between the plan's maximum allowable charge and the provider's higher charge is called the "balance bill." You will be responsible for paying the balance bill amount, along with any applicable copayments, coinsurance and deductibles. In addition, the balance bill will not apply to your out-of-pocket maximum.

COVERED SERVICES

Doctor Visits

Charges from your physician for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered. *Routine preventive care is not covered out of network.*

Chiropractic Care

You are covered for office services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. Other services that are within the scope of chiropractic care are also covered. *Chiropractic care is not covered out of network.*

Maternity Care

You and your dependent spouse are covered for hospital care, birthing center care, and prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. Inpatient benefits are provided for the mother and newborn for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Caesarean section, not including the day of surgery. Coverage for the newborn includes, but is not limited to, routine nursery care and/or routine well-baby care during this period of hospital confinement. Charges for home births are not covered. Pregnancy is not considered a pre-existing condition.

Inpatient Hospital Services

You are covered for inpatient hospital services at an acute care hospital, a skilled nursing facility or a long-term acute care hospital, including room and board, physician visits and consultations.

Outpatient Hospital Services

Charges for outpatient laboratory, X-ray, surgery and diagnostic tests are covered. Physical therapy, occupational therapy, and speech therapy are also covered subject to the limits listed in the Schedule of Benefits.

Rehabilitation Services

You are covered for short-term (acute phase of treatment) rehabilitation services that are expected to significantly improve your condition. Rehabilitation services are limited to physical therapy, occupational therapy, speech therapy and cardiac therapy. Speech therapy is covered only when used to restore speech abilities that have been lost due to injury or illness. Cardiac therapy is covered only after a major cardiac event.

Therapeutic Services

Charges for radiation therapy, cancer chemotherapy and respiratory therapy are covered.

Behavioral Health Services

You are covered for treatment of mental health conditions and substance abuse. Companion Benefit Alternatives (CBA) coordinates benefits for these services. To receive services from a network or an out-of-network mental health or substance abuse professional, you or your physician may contact CBA at 800-868-1032 for authorization and/or more information.

Emergency Services and Urgent Care

Emergency Services

You are covered for treatment of a *true medical emergency* **anywhere** in the world. If practical, you should call your personal physician first and follow his or her directions. However, in the case of a serious medical emergency, go to the nearest hospital or treatment center for help or call 911. You should then have someone notify your doctor and BlueChoice HealthPlan.

MUSC Options will cover emergency room care only if you are seeking treatment for symptoms that are severe and need immediate medical attention, or if your doctor authorized the emergency room visit. Conditions that are considered a medical emergency include those so severe that if you do not get immediate medical attention, one of the following conditions could occur:

- Severe risk to your health, or with respect to pregnancy, the health of your unborn child
- Serious damage to body function
- Serious damage to any organ or body part.

Follow-up care for emergency services must be received from providers within the MUSC Options network or arranged by MUSC Options.

For more information on receiving emergency services outside the MUSC Options service area, review the section on the BlueCard program.

Urgent Care

Urgent care is a medical condition that is serious but not life- or limb-threatening. If you need urgent care, you should call your personal physician. If you have an illness or injury that requires urgent care and you cannot get to your doctor or wait until normal business hours, you should go to a participating urgent care center. Please refer to the MUSC Options Provider Directory for the list of participating urgent care centers.

Urgent care required within South Carolina is covered when provided by a participating urgent care provider. Urgent care required outside South Carolina is covered when coordinated through the BlueCard program.

Out-of-network benefits are available for non-participating urgent care centers.

Ambulance

Charges for emergency ambulance transportation provided by a licensed ambulance service to the nearest hospital where emergency covered services can be rendered are covered. Coverage includes transportation between acute care facilities when a medically indicated transfer is needed.



For more information about the BlueCard program, see page 29 of this guide.

Hospice

You are covered for hospice care provided by a licensed hospice.

Medical Supplies

Charges are covered for medical supplies, including, but not limited to:

- Dressings requiring skilled application, for conditions such as cancer or burns
- Catheters
- Colostomy bags and related supplies
- Medically necessary supplies for renal dialysis equipment or machines
- Surgical trays
- Splints or such supplies as needed for orthopedic conditions
- Syringes, test tapes, and other related diabetic supplies not covered under other provisions of the plan.

Outpatient Private Duty Nursing Care and Home Health Services

You are covered for special or private duty nursing care provided by a registered nurse or a licensed practical nurse on an outpatient basis. Services must be provided in lieu of inpatient care.

You are covered for home health services provided by a licensed home health agency. Services must be provided in lieu of inpatient care.

Prosthetics

You are covered for a prosthetic device, other than a dental or cranial prosthetic, that is a replacement for a body part and meets minimum specifications. Only the initial prosthesis is covered. *Prosthetics are not covered out of network.*

Dental Services for Accidental Injuries

You are covered for dental services performed by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) to sound natural teeth when required because of accidental injury. For purposes of this benefit, an accidental injury is defined as an external traumatic force, such as a car accident or blow by a moving object. The first (emergency) visit to the dentist does not require authorization. However, the dentist must submit an outline of the plan for future treatment to BlueChoice HealthPlan for review and approval before continuing with follow-up care for that care to be covered. Follow-up care must be completed within 12 months of the accident.

Durable Medical Equipment

Charges for medically necessary durable medical equipment, such as wheelchairs, braces, hospital beds, traction equipment, inhalation therapy equipment and suction machines, and other equipment as approved by BlueChoice HealthPlan for outpatient use, are covered. Equipment is covered only when ordered, delivered and used while you are enrolled in MUSC Options.

Repair, replacement or duplicates of durable medical equipment are not covered, except when medically necessary due to a change in your medical condition. Appliances that serve no medical purpose and are solely for your comfort, such as a whirlpool bath, air conditioner or dehumidifier, are also not covered. *Durable medical equipment is not covered out of network.*

Reconstructive Surgery after a Mastectomy

If you are receiving benefits in connection with a mastectomy and/or elective breast reconstruction in connection with the mastectomy, you are covered for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications during all stages of mastectomy including lymphedemas.

This coverage is in compliance with the Women's Health and Cancer Rights Act of 1998.

Human Organ Transplant Services

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient) and provided at a designated transplant facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation are covered.

Please contact BlueChoice HealthPlan for more information regarding coverage for charges incurred by a living donor.

Transplants that are experimental, investigational or unproven are not covered. Transplants that are not determined by BlueChoice HealthPlan to be medically necessary are also not covered.

Infertility Services

You are covered for infertility services, including the following procedures and related services, supplies and prescription medications:

- Artificial insemination
- In-vitro fertilization (IVF)
- Gamete or zygote intra-fallopian transfer (GIFT or ZIFT).

Coverage for infertility services is subject to the following terms and conditions:

- Benefits are provided as specified in the Schedule of Benefits.
- Benefits are limited to covered services provided to you or your enrolled spouse.
- Benefits for GIFT, ZIFT and IVF are limited to a maximum of three complete cycles with a \$15,000 lifetime maximum.
- Coinsurance amounts are not included in the coinsurance maximum.
- Services for sperm banking/semen specimen storage are not covered.
- Services for any other assisted reproductive technology not specified herein are not covered.
- Fertility services are not covered out-of-network.

Vision Services

You are covered for vision services from any licensed vision care provider without authorization. Your plan will pay up to \$75. However, you are required to pay the provider's total charge and submit a claim to BlueChoice HealthPlan for reimbursement. See your Schedule of Benefits for more information on covered vision services.

PRESCRIPTION DRUG PROGRAM

MUSC Options participates in Rx Selections®, Medco Health Solutions Inc.'s pharmacy network. For a list of participating providers, go to www.eip.sc.gov. **Remember, benefits are only payable if you use a participating pharmacy or mail-order pharmacy.** You **must** show your ID card when purchasing medications.

MUSC Options Prescription Drug Program, administered by Medco, is easy and convenient to use. You show your MUSC Options identification card when you purchase prescription drugs from a participating pharmacy.

Prescription Drug Deductible and Copayments

MUSC Options has a \$100 prescription drug deductible. This means that each person covered under the plan, including dependents, must pay \$100 in allowable charges for covered prescription drugs before he can purchase covered prescription drugs for the copayment.

After you reach your \$100 deductible, you pay these copayments for up to a 31-day supply:

- \$10 for generic drugs
- \$30 for preferred brand drugs
- \$50 for non-preferred brand drugs
- \$100 for specialty pharmaceuticals.

After you reach your \$100 deductible, you pay these copayments for a 90-day supply of a prescription ordered from Medco's mail-order pharmacy:

- \$25 for generic drugs
- \$75 for preferred brand drugs
- \$125 for non-preferred brand drugs
- \$250 for specialty pharmaceuticals.

Pay the Difference

If a generic drug is available and you purchase the brand-name version instead, the benefit will be limited to the cost of the generic drug, even if your doctor instructs the pharmacist to “dispense as written.” You will be responsible for paying the difference between the cost of the generic drug and the cost of the brand-name drug.

Coordination of Benefits (COB)

MUSC Options coordinates prescription drug benefits and medical benefits. When you are covered by more than one insurance company, COB makes sure you are not reimbursed more than once for the same expense and that each company pays its fair share of the cost of your care.

When you are covered by more than one plan, the plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. MUSC Options determines which plan is primary. Here are some examples of how that works:

The plan that covers a person as an employee is primary to the plan that covers the person as a dependent. When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is considered primary.

When filling a prescription at a participating pharmacy, you may notice a difference in the amount MUSC Options pays.

If MUSC Options is primary

When you purchase a prescription drug, present your MUSC Options insurance card first. Your claim will be processed under the plan as if you had no other coverage. Then present the card for your secondary insurance coverage. If the pharmacy can pay secondary insurance claims electronically, benefits under that plan will be paid.

If MUSC Options is secondary

Present the card for your primary coverage first. If you present your MUSC Options card first, the claim will be initially denied because the MUSC Options is secondary. After the pharmacy processes the claim through your primary coverage, present your MUSC Options card and your claim will be processed through MUSC Options.

If the pharmacy cannot process secondary insurance claims electronically, the claim may be rejected. If this happens, you will need to file a paper claim for any MUSC Options benefits to Medco. Prescription drug claim forms are available through the EIP Web site at www.eip.sc.gov. Choose your category (“Active Subscriber,” for example) and then select “Forms.” You will see both the retail and mail-order pharmacy forms listed. Forms also are available from your benefits administrator.

Please remember: MUSC Options is not responsible for filing or processing your claims through another health insurance plan. That is your responsibility.

EXCLUSIONS AND LIMITATIONS

Although this plan covers a broad range of services, there are some exclusions and limitations. The following is a list of some of them. For a complete list of all exclusions and limitations, consult the Plan of Benefits.

1. Any services or supplies that are not medically necessary.
2. Any services or supplies for which you are not legally obligated to pay.
3. Any services or supplies for treatment of military service-related disabilities when you are legally entitled to other coverage and for which facilities are reasonably available to you.
4. Any services or supplies for which benefits are paid by Workers’ Compensation, occupational disease law or similar legislation.
5. Treatment of an illness contracted or injury sustained while engaged in the commission or an attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation (job); or treatment of an injury or illness due to voluntary participation in a riot or civil disorder.

6. Any charges for services provided before your effective date or after the end of coverage.
7. Admissions or portions thereof for sanitarium care, rest cures or custodial care.
8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery.
9. All services and supplies related to pregnancy of a dependent child. (Complication of pregnancy is covered. However, abortion is not considered a complication of pregnancy.)
10. Pre-conception testing, pre-conception counseling or pre-conception genetic testing.
11. Any drugs, services, treatment or supplies determined by the medical staff of BlueChoice HealthPlan, with appropriate consultation, to be experimental, investigational or unproven.
12. Drugs for which there is an over-the-counter equivalent; all vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for non-covered services, therapies or conditions; and drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, sexual dysfunction or smoking cessation.
13. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are medically necessary and due to physical trauma, surgery, or congenital anomaly (birth defect).
14. Therapy or services for learning disabilities, speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation and marriage counseling.
15. Any service or supply rendered to a person for the diagnosis or treatment of sexual dysfunction including, but not limited to, surgery, drugs, laboratory and X-ray tests, counseling, or penile implant necessary due to any medical condition or organic disease.
16. Hospital and physician services for dental procedures involving tooth structure, extractions, gingival tissue, alveolar process, dental x-rays or other procedures of dental origin that are principally for the preserving of teeth or the preparation of the mouth for dentures, even when due to accidental injury of natural teeth except for the following:
 - a. Treatment of an injury to sound natural teeth due to an accident if the treatment is provided and completed within 12 months after the accident.
 - b. Removal of a malignant tumor or cyst.
 - c. Removal of bony, impacted wisdom teeth.

This exclusion does not apply to facility and anesthesia services that are medically necessary because of a specific organic medical condition, such as a congestive heart failure or chronic obstructive pulmonary disease, that requires hospital-level monitoring.
17. Hearing aids.
18. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction or completion of medical records, itemized bills or claims forms.
19. Services or supplies not specifically listed in the Schedule of Benefits or the Covered Services section.
20. Transplant services other than as specified in the Schedule of Benefits or the Covered Services section.
21. Complications arising during, from or related to non-covered services. "Complications," as used in this exclusion, includes any medically necessary services or supplies which, in BlueChoice HealthPlan's judgment, would not have been required by you had you not received non-covered services.
22. The purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, waterbeds, exercise equipment or other similar items or equipment.
23. Any service or supply provided by a member of your family or by yourself, including the dispensing of drugs. "A member of your family" means your spouse, parent, grandparent, brother, sister, child or your spouse's parent.
24. Charges for acupuncture, hypnotism, biofeedback and TENS unit. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow you to develop pain coping skills and freedom from dependence on analgesic medications.

25. Orthomolecular therapy, including nutrients, vitamins and food supplements, that is aimed at or related to restoring the optimal concentrations and molecular level functions of substances such as non-traditional vitamins and base elements in the body through the use of macrobiotics.
26. Radial keratotomy, myopic keratomileusis, LASIK surgery, and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting vision problems such as myopia, hyperopia or stigmatic error.
27. Treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, for services and supplies for non-surgical treatment of the feet, or for cutting, removal or treatment of corns, calluses or nails. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease.
28. Infant formula, nutrition counseling, lifestyle improvements or physical fitness programs.
29. Communications, travel time, transportation, except for use of professional ambulance services.
30. Cranial orthotics used on infants with misshapen heads to progressively mold the skull to a normal shape.
31. Sclerotherapy for cosmetic purposes, such as removal of spider veins.
32. Growth hormone therapy for patients over 18 years of age. (Growth hormone therapy for patients age 18 and younger with documented growth hormone deficiency is covered.)
33. Pulmonary rehabilitation, except in conjunction with a covered lung transplant.
34. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges
35. Surgery for treatment of obesity, including, but not limited to, gastric bypass or stapling, intestinal bypass and any related procedures. Benefits for the surgical revision, reversal or the treatment for the consequences of bariatric surgery, such as abdominoplasty, are limited to procedures which are medically necessary to treat intractable functional problems that are refractory to medical or non-surgical treatment.
36. Treatment for weight reduction, weight control, or nutritional counseling, except for the MUSC Weight Management Program.
37. Any procedure, drug, treatment or service for or related to an elective abortion.
38. Services or supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint (TMJ) disorders except for surgical treatment of TMJ.
39. Voluntary sterilization within one year of enrollment in any of the medical plans sponsored by the Employee Insurance Program (EIP).

OTHER PLAN FEATURES

Away From Home Care

Any time you or one of your family members will be out of South Carolina for more than 90 days, you can become a guest member of an affiliated Blue Cross and Blue Shield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two groups that can benefit from Away From Home Care. If you need to use the Away From Home Care program, call Member Services at 800-821-3023 (382-5026 in the Columbia area) and ask to speak to the Away From Home Care program coordinator, or visit www.BlueChoiceSC.com for more information.

Great Expectations for health

Great Expectations *for health* programs are designed to help you improve your health by providing you with educational information and professional support from health specialists. MUSC Options members may participate in these programs at no charge or for a small, one-time fee.

Great Expectations *for health* offers programs for:

- Asthma
- Children's Health
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- Maternity
- Men's Health
- Migraine
- Quit Smoking
- Women's Health
- Weight Management.

For more information on these programs, call the Health Management department at 800-327-3183, ext. 25541, or you may visit www.BlueChoiceSC.com.

Value-Added Services

There are many ways to stay healthy. Value-Added Services are offered in addition to, but not a part of, the services and benefits covered under the MUSC Options plan. Through the Natural Blue program, you have access to special discounts on services from a network of acupuncturists, massage therapists, chiropractors, day spas and fitness centers in South Carolina and throughout the country.

Value-Added Services also include Vision Care. As an MUSC Options member, you are eligible for one exam for glasses per year from a participating provider. (Contact lens exam and fitting cost are extra.) You are also eligible for frames from a designated selection every two years or credit toward the purchase of contacts.

Additional Value-Added Services include:

- LASIK services
- Alternative medicine
- Hearing tests and aids
- Weight loss programs and centers
- Magazine subscriptions
- Cosmetic surgery discounts
- Cosmetic dentistry discounts.

For more information or to find a provider, please call Member Services at 800-821-3023 or visit www.BlueChoiceSC.com.

APPEALS

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received.

To request an appeal, you (or your designated representative) may contact Member Services at 800-821-3023 (382-5026 in the Columbia area). If you prefer, you may send a written appeal request to:

BlueChoice HealthPlan
Member Services (AX-425)
P.O. Box 6170
Columbia, SC 29260-6170.

You may also e-mail your appeal request to BlueChoice HealthPlan through www.BlueChoiceSC.com. Just sign on to *My Insurance Manager* and click on *Ask Customer Service*.

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal, and send you notification of that decision, within 30 days of receipt of your appeal request.

If you are dissatisfied with the decision, you may ask EIP for a review by sending a written request to EIP within 90 days of receiving notice of our decision on your appeal. If the EIP Appeals Committee upholds BlueChoice HealthPlan's decision, you will have 30 days to seek review in the Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

If you need more information about the appeal process, contact Member Services by phone, letter or e-mail as indicated above.

MEDICAL WEB SITE: WWW.BLUECHOICESC.COM

If you wish to download forms, learn specifics about your health plan, send BlueChoice HealthPlan an e-mail or read about wellness programs, you can do all that and more at www.BlueChoiceSC.com. This Web site is protected, secure and convenient way for you to read timely information on your own schedule.

My Insurance Manager enables you to:

- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you have paid toward your deductible or out-of-pocket limit
- Ask a customer service question through secure e-mail
- Request a new ID card.

PRESCRIPTION DRUG WEB SITE: WWW.MEDCO.COM

Prescription drugs are a major benefit offered through your HMO and a major cost of our self-insured health plans. Learning more about them will help you stay healthier and save money. For more information about your drug plan, visit www.medco.com.

Medco's Web site enables you to:

- Order prescriptions by mail
- Learn about savings opportunities
- Price drugs
- Print forms
- Find a network pharmacy
- Review up to 18 months of your prescription drug history
- Get up-to-date information about your drug benefits.

[®]*Registered mark of the Blue Cross and Blue Shield Association*

^{sm†}Service mark of BlueCross BlueShield of South Carolina

BlueChoice HealthPlan is a wholly owned subsidiary of BlueCross BlueShield of South Carolina. Both are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

